

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address STAT 2000 P.O. Box 15640 Fort Worth, TX 76119	MDR Tracking No.: M4-04-3023-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address BOX #: 19 Fidelity and Guaranty Insurance Company C/o Gallagher Bassett Services, Inc.	Date of Injury:
	Employer's Name: Sysco Corporation
	Insurance Carrier's No.: 011924004154WC01

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/30/02	10/30/02	E1399 Large Hot/Cold Back Pack	109.90	109.90
		E1399 Aloe liniment, one liter	44.73	44.73
Total Amount Due				\$154.63

PART III: REQUESTOR'S POSITION SUMMARY

Detailed description of the merchandise show the product is new to the market and is unique in that it is able to provide the patient with either hot (non-electric moist heat) or cold therapy. The wrap can also be used in the work environment, which makes it easier for the patient to receive relief without having to take medications on the job. Unlike conventional therapy products these wraps can be reheated up to 400 times without losing their effectiveness, making the product very cost effective and our profile fair and reasonable. As there is not a MAR for this product, copies of retail suggested price list and audit sheets and copies of checks where other carriers have established the charges for the above disputed items as fair and reasonable.

PART IV: RESPONDENT'S POSITION SUMMARY

In respect to the universal hot/cold pack, Requestor claims the brand used is "new", but cannot otherwise show this brand was medically necessary. The claim the item is "unique" is false. Reusable hot/cold gel packs have been on the market at least 20 years. The brand used is "unique" only in price. There is no evidence the brand supplied was medically necessary. One can even get this type of item with the addition of magnets for \$39.95! Carrier reimbursed Requestor \$70.00, which appears to be an overpayment.

The denial reasons mentioned on the EOBs were "Payment determined" and "Invoice not attached to document the cost of supply or injection. Please resubmit with invoice."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The carrier asserts that the item is not unique, not medically necessary and offers that this item can be purchased for \$39.95. However, there is no other literature or research provided for this review to support how this amount was derived or how this item is not unique. The Respondent now asserts that the item is not medically necessary, however, this defense is a new issue that was not raised during the carrier's audits or presented to the Requestor prior to this medical dispute (§133.307(j)(2)).

There exists no equivalent to the disputed items within the 1996 or 1991 Medical Fee Guidelines nor a reference to any similar item in the Medicare DMERC fee schedule. As such the item is unique and reimbursement is subject to fair and reasonable standards §413.011. The Requestor provides a price list from their vendor, Alternatives Medical, which reflect the same charges in dispute. Also provided were samples of other carrier EOB payments, including EOB samples from the Respondent's bill payer, Gallagher Bassett, which established fair and reasonable reimbursement equal to the amounts charged by the Requestor.

Based on all the above, the Requestor proves the carrier's reimbursement is not fair and reasonable.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **\$154.63**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Patti Lanfranco

July 14, 2005

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
P. O. Box 17787
Austin, Texas, 78744
or faxed to (512) 804-4011

A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____